Bureau of Licensure and Certification

PRINTED: 09/03/2008
FORM APPROVED

POC accepted 9/30/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1218SNF	A. BUILDING ______ B. WING ______	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE PINE CARE CENTER	1500 AVENUE G ELY, NV 89301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	Initial Comments This Statement of Deficiencies was generated as the result of a State licensure survey conducted at your facility from August 18, 2008 through August 21, 2008. The survey was conducted using Nevada Administrative Code (NAC) 449, Skilled Nursing Facilities Regulations, adopted by the Nevada State Board of Health on August 4, 2004. Ten personnel records were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	Z 000	**White Pine Care Center, Ely NV Plan of Correction for Annual Survey, ending 8/21/08** **Z342 SS=D** **NAC 449.745511 Personnel Records-Licenses, TB, Background** **Corrective Action for employees # 2 & #5.** Two step TB tests completed. **Other Employees Potentially Affected:** Employees potentially affected include all new employees requiring a two step TB test for employment.	
Z342 SS=D	NAC 449.74511 Personnel Records - Licenses, TB, Background 3. A current and accurate personnel record for each employee of the facility must be maintained at the facility. The record must include, without limitation: a) Evidence that the employee has obtained any license, certificate or registration, and possesses the experience and qualifications, required for the position held by the employee; b) Such health records as are required by chapter 441A of NAC which include evidence that the employee has had a skin test for tuberculosis in accordance with NAC 441A.375; and c) Documentation that the facility has not received any information that the employee has been convicted of a crime listed in paragraph (a) of subsection 1 of NRS 449.188.	Z342	**Measures to prevent reoccurrence:** Upon completion of second step of two step by the staff nurse designee the new employee will be given a note signed by the nurse and dated stating that he/she has completed their second step. This is to be delivered by the employee to HR. HR will then maintain this note and follow up as necessary on paydays when HR will have direct contact with the employee and can direct him/her to complete the process as necessary in an expedient manner.	

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 9/15/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1218SNF	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE PINE CARE CENTER	1500 AVENUE G ELY, NV 89301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z342	Continued From page 1 This Regulation is not met as evidenced by: Based on personnel file review and interview, it was determined the facility failed to provide evidence of a two-step tuberculin skin test for 2 of 10 employees. (#2, #5) Findings include: Employee #2: The employee was hired on 6/7/08. An initial first step tuberculin skin test was performed. However, there was no evidence of a second step tuberculin skin test. The personnel officer indicated the test had not been completed. Employee #5: The employee was hired on 5/17/08. An initial first step tuberculin skin test was performed. However, there was no evidence of a second step tuberculin skin test. The personnel officer indicated the test had not been completed. Severity 2 Scope 1	Z342	**Measures to monitor program effectiveness:** Monthly CQI will include a follow up report from HR regarding training, TB testing and orientation. This information will be given to each department manager in the CQI meeting and a date/time for completion will be established at that meeting as necessary. **The responsible party for monitoring and accomplishing compliance** will be the HR Coordinator/Assistant Office Manager. **Anticipated Date of Correction: 9/30/08** **Z393 SS=D** **NAC 449. 74522 Personnel Training in Dementia** **Corrective Action for employees #5, #7, #8, #9.** Dementia training for all identified employees to be completed by 9/19/08. **Other Employees Potentially Affected:** All new employees providing direct care and services to residents are affected.	
Z393 SS=D	Personnel Training in Dementia NAC 449.74522 Employees of facility which provides care to persons with dementia. 1. Except as otherwise provided in subsection 4, each person who is employed by a facility for skilled nursing which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, who has direct contact with and provides care to persons with any form of dementia and who is licensed or certified by an occupational licensing board must complete the following number of hours of continuing education specifically related to dementia:	Z393		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1218SNF	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE PINE CARE CENTER	1500 AVENUE G ELY, NV 89301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z393	Continued From page 2 (a) In his first year of employment with a facility for skilled nursing, 8 hours which must be completed within the first 30 days after the employee begins employment; and (b) For every year after the first year of employment, 3 hours which must be completed on or before the anniversary date of the first day of employment. 2. The hours of continuing education required to be completed pursuant to this section: (a) Must be approved by the occupational licensing board which licensed or certified the person completing the continuing education; and (b) May be used to satisfy any continuing education requirements of an occupational licensing board and do not constitute additional hours or units of required continuing education. 3. Each facility for skilled nursing shall maintain proof of completion of the hours of continuing education required pursuant to this section in the personnel file of each employee of the facility who is required to complete continuing education pursuant to this section. 4. A person employed by a facility for skilled nursing which provides care to persons with any form of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, is not required to complete the hours of continuing education specifically related to dementia required pursuant to subsection 1 if he has completed that training within the previous 12 months. 5. As used in this section, " continuing education specifically related to dementia " includes, without limitation, instruction regarding: (a) An overview of the disease of dementia, including, without limitation, dementia caused by Alzheimer ' s disease, which includes instruction on the symptoms, prognosis and treatment of the disease;	Z393	**Measures to prevent reoccurrence:** DNS re-instructed 8/21/08 regarding Dementia training. HR coordinator re-trained 9/11/08 regarding Dementia training requirements. New employees will be removed from work schedule if dementia training is not completed within thirty days of hire and will not be reinstated until compliant with requirements. New hire packets will address mandatory dementia training as part of orientation requirements. **Measures to monitor program effectiveness:** Monthly CQI will include a follow up report from HR regarding training. This information will be given to each department manager in the CQI meeting and a date/time for completion will be established at that meeting as necessary. **The responsible party for monitoring and accomplishing compliance** will be Director of Nursing Services and/or designee. **Anticipated Date of Correction: 9/30/08**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1218SNF	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE PINE CARE CENTER	1500 AVENUE G ELY, NV 89301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z393	Continued From page 3 (b) Communicating with a person with dementia; (c) Providing personal care to a person with dementia; (d) Recreational and social activities for a person with dementia; (e) Aggressive and other difficult behaviors of a person with dementia; and (f) Advising family members of a person with dementia concerning interaction with the person with dementia. This Regulation is not met as evidenced by: Based on personnel file review and interview, it was determined the facility failed to provide evidence of 8 hours of dementia training within 30 days of hire for 4 of 10 employees. (#5, #7, #8, #9) Findings include: Employee #5: The employee was hired on 5/17/08. There was no evidence of dementia training in the file. The personnel officer indicated the training had not been conducted within thirty days of hire. Employee #7: The employee was hired on 6/6/08. There was no evidence of dementia training in the file. The personnel officer indicated the training had not been conducted within thirty days of hire. Employee #8: The employee was hired on 6/10/08. There was no evidence of dementia training in the file. The personnel officer indicated the training had not been conducted within thirty days of hire.	Z393	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE PROVIDER'S ADMISSION OR AGREEMENT THE FACTS ALLEGED OR CONCLUSIONS IN THE STATEMENT OF DEFICIENCIES CORRECTION SOLELY BECAUSE OF THE PROVISIONS OF FEDERAL AND STATE LAWS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN1218SNF	A. BUILDING _____ B. WING _____	08/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE PINE CARE CENTER	1500 AVENUE G ELY, NV 89301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z393	Continued From page 4 Employee #9: The employee was hired on 7/7/08. There was no evidence of dementia training in the file. The personnel officer indicated the training had not been conducted within thirty days of hire. Severity 2 Scope 2	Z393		